



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Charles Kennedy, M.D.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-16-3818-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

August 25, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "On the day of the evaluation, Dr. Kennedy referred [the claimant] for an FCE to address the Return to Work issues.

This was an usual [sic] case in the fact that Dr. Kennedy had to refer [the claimant] to a Retinal Specialist to assist in determining the Extent of Injury. This did not take place until April 25, 2016.

Once our office received the report from the specialist Dr. Kennedy completed his report.

Therefore the billing time frame is from March 14, 2016 through May 09, 2016 when Dr. Kennedy completed his report."

**Amount in Dispute:** \$799.07

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed for an FCE with code 99456FC... Texas Mutual received this bill 5/17/16 and declined to issue payment on 6/10/16 absent correct coding.

The requestor submitted a 'Corrected' bill with code 97750-FC that Texas Mutual received 6/28/16... This bill constituted a new bill past the filing time frame prescribed by Rule 133.20. For this reason Texas Mutual denied payment."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2016	Functional Capacity Evaluation	\$799.07	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
3. 28 Texas Administrative Code §133.250 sets out the procedures for submitting a request for reconsideration of a medical bill.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
  - CAC-29 – The time limit for filing has expired.
  - 731 – Per 133.20(b) provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service.
  - 854 – Documentation does not support the initial use of the medication for this patient.
  - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 724 – No additional payment after a reconsideration of services.

## **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

## **Findings**

1. The requestor is seeking reimbursement for a functional capacity evaluation. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “THE TIME LIMIT FOR FILING HAS EXPIRED,” and 731 – “PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.” 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Texas Labor Code §408.0272(b) provides, in relevant part, that:
  - (b) Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
    - (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
      - (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
      - (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
      - (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
    - (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider...
  - (d) Notwithstanding any other provision of this section or Section 408.027, the period for submitting a claim for payment may be extended by agreement of the parties.

The requestor argued that the division’s extension for the designated doctor’s examination report included an extension for billing the functional capacity evaluation. The division finds that this exception is not addressed in Texas Labor Code §408.0272. No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

2. Texas Labor Code §408.027(a) states that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.”

In its position statement, the requestor argued that it submitted a “Request for Reconsideration” with a corrected (new?) procedure code, on July 28, 2016 for the bill in question. 28 Texas Administrative Code §133.250(d) requires that a request for reconsideration “reference the original bill and include the **same billing codes** [emphasis added], date(s) of service, and dollar amounts as the original bill.”

Review of the submitted information finds no documentation to support that a medical bill for the disputed services was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### **Authorized Signature**

_____	Laurie Garnes	September 29, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**